



Sports Related Skin Infections **Position Statement and Guidelines**

**National Federation of State High School Association (NFHS)
Sports Medicine Advisory Committee (SMAC)**

Skin-related infections in both the community setting and the sports environment have increased considerably over the past several years. While the majority of these infections are transmitted through skin-to-skin contact, a significant number are due to shared equipment, towels or poor hygiene in general. The NFHS Sports Medicine Advisory Committee (SMAC) has put forth general guidelines for the prevention of the spread of these infectious diseases (See NFHS General Guidelines for Sports Hygiene, Skin Infections and Communicable Diseases).

The NFHS SMAC recognizes that even with strict adherence to these guidelines, given the nature of certain sports, skin infections will continue to occur. For example, the risk of transmission is much higher in sports with a great deal of direct skin-to-skin contact, such as football and wrestling. Therefore, the NFHS SMAC has developed specific guidelines for the skin infections most commonly encountered in sports. The guidelines set forth follow the principles of Universal Precautions and err in favor of protecting participants in situations where skin-to-skin contact may occur. Consideration may be given to the particular sport regarding risk of transmission, but these rules must be strictly adhered to in sports such as wrestling, football and basketball where skin-to-skin contact is frequent and unavoidable.

Ringworm, Tinea Corporis

These fungal lesions are due to dermatophytes. As they are easily transmissible, the athlete should be treated with an oral or topical antifungal medication for a minimum of 72 hours prior to participation. Once the lesion is considered to be no longer contagious, it may be covered with a bio occlusive dressing. For scalp involvement, the infection is more difficult to treat and requires a full two weeks of oral antifungal medication before return to practice or competition.

Impetigo, Folliculitis, Carbuncle and Furuncle

While these infections may be secondary to a variety of bacteria, they should all be treated as Methicillin-Resistant Staphylococcus aureus (MRSA) infections. The athlete should be removed from practices and competition and treated with oral

antibiotics. Return to contact practices and competition may occur after 72 hours of treatment, provided the infection is resolving.

All lesions should be considered infectious until each one has a well-adherent scab without any drainage or weeping fluids. Once a lesion is no longer considered infectious, it should be covered with a bio-occlusive dressing until complete resolution.

All team members should be carefully screened for similar infections. If multiple athletes are infected, consideration should be given to contacting the local Public Health Department or team physician for guidance.

Shingles, Cold Sores

These are viral infections which are transmitted by skin-to-skin contact. Lesions on exposed areas of skin that are not covered by clothing, uniform or equipment require the player to be withdrawn from any activity that may result in direct skin-to-skin contact with another participant. Covering infectious lesions with an occlusive dressing is not sufficient or acceptable. Primary outbreaks of shingles and cold sores require 10-14 days of oral antiviral medications; while recurrent outbreaks require five days of treatment as a minimum treatment time, prior to returning to participation. To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge, and no new lesions should have occurred in the preceding 48 hours.

Herpes Gladiatorum

This skin infection, primarily seen among wrestlers, is caused by Herpes Simplex Virus Type 1 (HSV-1). The spreading of this virus is strictly skin-to-skin. The preponderance of the outbreaks develop on the head, face and neck, reflecting the typical lock-up position. The initial outbreak is characterized by a raised rash with groupings of 6-10 vesicles (blisters). For head, face and neck involvement, symptoms include sore throat, fever, malaise and swollen cervical lymph nodes. Primary outbreaks are much more extensive and may take up to two weeks to clear. The infected individual must be immediately removed from contact. Return to contact is permissible only after all lesions are healed with well adherent scabs, no new vesicle formation and no swollen lymph nodes near the affected area. Oral antiviral medications should be started and can expedite the clearing of an outbreak. Consideration should be given to prophylactic oral antivirals for the remainder of the season and each subsequent season.

Recurrent outbreaks usually involve a smaller area of skin, milder systemic illness and a shorter duration of symptoms. Treatment should include oral antivirals. If antiviral therapy is initiated, the participant must be held from wrestling for five days. If antivirals are not used, the infected participant may return to contact only after all lesions are well healed with well adhered scabs, no new vesicle formation in the preceding 48 hours and no swollen lymph nodes near the affected area. Even greater consideration should be given to

prophylactic antivirals for the remainder of the season. As the herpes virus may spread prior to vesicle formation, anyone in contact with the infected individual during the three days prior to the outbreak must be isolated from any contact activity for eight days and be examined daily for suspicious skin lesions.

Miscellaneous Viral Infections

Molluscum contagiosum and verruca (warts) are skin infections that are caused by viruses, but are not considered highly contagious. Therefore, these lesions require no treatment or restrictions, but should be covered if prone to bleeding when abraded.

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